

NARRATIVE THERAPY IN AN ABLEIST SOCIETY: INVITING ALTERNATIVE
STORIES INTO THE ROOM

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Abigail A. Waugh

Smith College School for Social Work
Northampton, Massachusetts 01063

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TABLE OF CONTENTS

ACKNOWLEDGMENTS.....	ii
TABLE OF CONTENTS.....	iii
CHAPTER	
I. INTRODUCTION.....	1
II. THE SOCIAL MODEL OF DISABILITY.....	6
III. NARRATIVE THERAPY.....	22
IV. EXAMPLES OF ALTERNATIVE STORIES.....	34
V. CONFRONTING ABLEISM IN NARRATIVE WORK.....	40
VI. CONCLUSION.....	50
REFERENCES.....	54

CHAPTER I

INTRODUCTION

ableism, *n* Discrimination in favour of able-bodied persons; prejudice against or disregard of the needs of the disabled (Simpson, et al, 1997)

People with disabilities make up approximately one fifth of the total population of the United States (United States Department of Commerce, 1997). In past decades, disability rights advocates fought for basic civil rights for Americans with disabilities, culminating with the passage of the Americans with Disabilities Act in 1990. Researchers within the applied fields, such as education and rehabilitation, are increasingly examining the impact of disability on daily life. In addition, scholars of disability studies have worked to build a dialogue about disability that includes disabled voices. Despite these fundamental advances, people with disabilities remain in the margins of our society.

As a social work student and a person who lives with multiple sclerosis, I was drawn to clinical social work literature about individuals with disabilities. I was, however, disappointed both by the scarcity of literature on disability and by the tone of the existing literature. In order to find an in-depth discussion of disability, which does not focus on diagnostic criteria or personal tragedy, I had to read literature produced outside the field of social work. Social work clinicians continue to locate disability primarily within individuals, rather than within our society.

In reading theories produced within the field of disability studies, including Lennard J. Davis's *The Disability Studies Reader*, I discovered new vocabularies and

theoretical concepts, which differed from the discourses of the applied fields, including social work. Simi Linton's *Claiming Disability* (1998) further convinced me that professionals in the helping professions, including clinical social workers, need to be cognizant of the *social model of disability*. Social model theorists from the disability rights movement and disability studies perspective argue that disability is socially constructed rather than an individual trait (Linton, 1998; Swain, French, & Cameron, 2003). The social model of disability will be examined in Chapter Two.

Definitions of disability and impairment, along with major concepts from social model theorists will be also be explored in more depth in the second chapter. The focus of this study will not be on any particular impairment, but on the ways in which the broader category of disability is socially constructed and how this influences the lives of people with disabilities, regardless of the nature of their impairment. The few existing social work texts on disability offer concise "how to" chapters that give suggestions for working with people with specific impairments. (Mackelprang & Salsgiver, 1999; Rothman, 2003). While understanding key issues for specific disability populations is crucial, social workers have done this at the expense of examining systemic issues that affect clinical work.

Ableism, or discrimination against people based on ability, is still firmly rooted within our cultural consciousness. Clinical social workers and other helping professionals are not exempt from the prejudices of the larger society. They regularly adhere to therapeutic models that label people with disabilities in pathologizing ways and continue to disempower clients by not acknowledging ableism within themselves and the society at large.

Some clinicians and academic theorists have questioned ideologies and practices, which oppress people with disabilities. For example, *narrative therapists*, who locate problems outside of individuals, work to resist mainstream, problem-saturated discourses about people with disabilities and work with clients to find alternative stories (Freedman & Combs, 1996; Morgan, 1998; Perry, 1998; White & Denborough, 1998).

Narrative therapy has powerful implications for work with oppressed populations, including people with disabilities. Narrative therapy's mantra: "The person is not the problem, the problem is the problem," complements concepts produced by social model theorists who posit that disability is created by social systems, rather than by a negative trait residing within an individual. Therefore, narrative therapy constitutes an ideal vehicle for formulating disability using a social model because narrative therapists are already attuned to questioning *thin descriptions*. Thin descriptions are meanings people have ascribed to their lives, which usually do not allow space for the complexity and contradictions within life and often end up disempowering people (Morgan, 2000, pp. 12-14).

Social workers cannot achieve their goal of social justice for people with disabilities by continuing to ignore the influence of ableism on clients' lives within clinical work. Social justice is valued so highly in the social work profession that it has been included in the *NASW Code of Ethics* (1999). However, advocating for social justice is often perceived as a task separate from clinical work. Sachs and Newdom (1999) argued that maintaining the dichotomy between social action and clinical work maintains the status quo (p. 3). The status quo for people with disabilities, as well as other oppressed groups, is unacceptable from a social justice perspective.

Narrative therapy requires clinicians to explore the stories their clients are telling about themselves. By helping clients externalize problems and consider alternative stories, narrative therapists ask clients to think about different ways of viewing themselves and their lives. Narrative therapists have been attentive to considering how societal oppression influences the lives of the people with whom they work (Monk & Gehart, 2003). They have also been working on ways to stop recreating oppression within the therapeutic relationship. The Just Team at The Family Centre of Lower Hutt, New Zealand has created gender and cultural caucuses, which allow marginalized groups to have more input at the Center (Freedman & Combs, 1996, pp. 279-280). Michael White, a pioneer in narrative therapy, has been working at the Dulwich Centre with people who hear voices and have been diagnosed with schizophrenia (Freedman & Combs, p. 207). Narrative therapists have started the process of acknowledging and valuing people outside the dominant group, including people with disabilities. Narrative therapy is addressed in Chapter Three.

This theoretical study reviewed (1) major concepts from the social model of disability and (2) key components from narrative therapy in order to answer the following research question: Can integrating an understanding of the social model of disability into narrative therapy practice enable therapists and clients to deconstruct ableist narratives and elicit alternative stories that have empowering implications for clients with disabilities?

In Chapter Four, two groups of people who are already telling alternative stories about their lives are examined. My purpose here is to expose clinical social workers to discourse about people with disabilities that are empowering rather than problem-

saturated. In addition, these narratives offer examples of ways in which the problematic dominant narrative about people with disabilities can be deconstructed. The group narratives include: (1) Deaf culture and (2) the Psychiatric Survivor/Consumer movement.

Although narrative therapy theory and social model theory reside in different disciplines, they share several influences. Social movements, such as the civil rights movement and feminism, have had an impact on both groups. Both narrative therapy and the social model of disability have grown out of postmodern and social constructionist discourses. While disability studies scholars tend to work in the abstract and narrative therapists are applying their theories to direct work with people, the two fields have much to offer one another. Chapter Five provides a discussion about the possibility of using concepts from the social model of disability to confront ableism in narrative therapy work.

Both narrative therapy theory and disability studies discourses are comprised of many perspectives. I offer a brief historical overview and some basic concepts from both theoretical groups. My focus, however, is on ways in which these concepts can be integrated in order to bring increased awareness about the lives of people with disabilities within an ableist society to the field of clinical social work. In the final chapter questions brought about by this theoretical study and ideas for implementation of the concepts discussed, as well as areas for future studies are considered.

CHAPTER II

THE SOCIAL MODEL OF DISABILITY

This chapter focuses on the theoretical shift away from using the medical model to understanding disability through a social model. Several groups, including disability studies theorists and some within the disability rights movement have advocated for this shift. While the medical model and the social model are not the only theoretical lenses for considering disability, they are two of the major models that are frequently compared. Although I am primarily considering how concepts from the social model of disability could be useful in narrative therapy work, an understanding of the medical model creates a context for understanding the emergence of the social model of disability.

Many scholars have contributed to the social model of disability, and they are not all in agreement about the components of this model. Although I refer to a singular social model of disability, I also strive to include several different voices from disability scholars in order to acknowledge the diversity of views within the field.

Two other topics to be covered in this chapter are: (1) the challenges in using language to describe disability and (2) the concept of ableism. These two foci, along with an appreciation of the social model of disability, are useful in drawing a connection between the social model of disability and narrative therapy in later chapters.

From a Medical to Social Model of Disability

Winter (2003) argued that activists in the disability rights movement were determined to replace the medical model with a social model of disability as part of their larger goal of the liberation of people with disabilities and their inclusion into the larger

society. Winter's examination of the transfer from one model to another gives a helpful framework for considering the differences between the two models and the reasons why so many disability activists and scholars have promoted a social model. At the same time, it is important to consider critiques of the emerging social model and to acknowledge that, in reality, people with disabilities have interactions with people who understand disability in many different ways, including through a medical lens.

The Medical Model

The *medical model*, despite its frequent criticisms by people with disabilities, remains a common model for framing discussions about disability. In this model, medical professionals (and others, including social workers) define disability. The role of the professional is that of the expert who has the power to diagnose and name *impairments* within individuals. An impairment is "a physical or biological condition, including, of course, cognitive impairment" (Winter, 2003, para 16). The person with the impairment is the patient who is acted upon by the professional. The goal within the model is the removal, cure, or reduction of the impairment.

Swain, French, and Cameron (2003) noted that within the medical model, *disability* is conceptualized as an individual problem, related to functional limitations of the bodies of people with impairments. In fact, they articulated that within this model the culture and environment within which the person with the impairment exists is irrelevant. Swain, French, and Cameron viewed this model as a means of reinforcing society's dominant ideas about individuals and their roles, placing a high importance on conformity and self-reliance. Swain, French, and Cameron also argued that this model has been imposed on people with disabilities by non-disabled people.

Similarly, Winter (2003) contended:

The medical model, then, constitutes a plausibility structure, a set of policies and procedures, whose implicit premises, namely, those defining the privileges and obligations of the sick role, unobtrusively control, indeed, oppress, persons with impairments and rend them disabled and dehumanized (para 29).

For Winter, replacing the medical model with the social model was crucial to the ideological battleground of the disability rights movement. The other two important aspects of the disability rights movement were: (1) the passage of new legislation, especially the 1990 Americans with Disabilities Act, and (2) organizational change, such as the creation of Independent Living Centers where people with disabilities are responsible for their own lives. These two components of the disability rights movement, while important, are not the focus of this study.

Dorn (1999) has pointed to one way in which people can be exploited by over extending the boundaries of medically-defined disability, specifically the profits gained by pharmaceutical companies through increasing awareness of ‘psychiatric disability.’ Dorn refers specifically to the sales of products such as stimulants. Certainly the pharmaceutical industry has benefited from the promotion of various classes of drugs for psychiatric conditions. Yet, Butler and Parr (1999) also noted that medical research and technology can improve the lives of people with disabilities, which is also relevant here. It is crucial to consider in these scenarios whether the person with the disability is choosing the technology or treatment, or whether it is being imposed on them by medical professionals or societal pressures to be ‘normal.’”

Kane (1982) warned social workers against completely vilifying the medical model, arguing that instead of creating a false dichotomy they should find ways of

integrating health care and social services. Kane pointed out that many people are medically underserved and that this is more dangerous than medical dominance.

However, I do not believe the disability rights perspective is arguing for fewer medical services or less medical treatment. Indeed, health care should be a fundamental right and one that people with disabilities frequently do not have access to because of their limited access to employment and benefits. I would argue instead that the view of disability right advocates is that people with disabilities should not be relegated to the role of a permanent, passive patient, but should have control over their interactions with medical professionals.

Butler and Parr (1999) acknowledged that the research produced within the medical model benefits people with disabilities by developing technology that has the potential to improve their daily life. However, Butler and Parr clearly assert that, through the medical model and the rise of the medical sciences, Western society has been able to socially categorize and pathologize people with disabilities.

Disability Studies

It is useful to consider the social model of disability within the context of disability studies. In the passage below, Swain, French, and Cameron (2003) wrote a helpful synopsis of the emerging academic field of disability studies.

Disability studies is a burgeoning domain of study, as is evident in the growth of courses, research and literature. It has its roots in the growth of the disabled people's movement within Britain and internationally, and the foundation of the social model of disability. Disability studies is centrally the study of the disabling society. At its best it is an arena of critical debate addressing controversial issues concerning, not just the meaning of disability, but the nature of society, dominant values, quality of life, and even the right to live (Swain, French, and Cameron, 2003, p. 1).

Dowse (2001) examined how disability studies evolved as a movement by incorporating social movement theory into her analysis. Historically, social movements relied on the formation of collective identities. Difference, however, has been with disability studies from its beginnings. Dowse noted that “criticisms of inclusion and representation within the movement have come from those on its margins; disabled women, black disabled people, those from ethnic minorities and gay and lesbian disabled people” (2001, p. 133). Dowse, by incorporating social movement theory, has argued for a “textured exploration of collective identity” within the disability studies movement.

The Social Model

Swain, French, and Cameron (2003) contended that the social model gives people with disabilities a means to locate the real problems of disability within their society and a way to organize around the goal of inclusion within society. The problems of disability, rather than being located within the individual as in the medical model, are found within the society itself in the form of physical and attitudinal barriers, low expectations, and limited opportunities for people with disabilities.

According to Barnes, Mercer, and Shakespeare (1999), under the social model any meaningful solution must come from societal change rather than adjustment or rehabilitation of the individual. They wrote:

The social model focuses on the experience of disability, but not as something which exists purely at the level of individual psychology, or even interpersonal relations. Instead, it considers a wide range of social and material factors and conditions, such as family circumstances, income and financial support, education, employment, housing, transport and the built environment, and more besides (p. 31).

These physical and social barriers are neglected within the medical model, which limits

itself to the body of the individual. For example, within a medical model a child diagnosed with ADHD is viewed as possessing the disability. In the social model, the problem of disability is primarily located outside the child in his or her social environment.

Physical Barriers. Awareness about physical barriers for people with disabilities continues to increase. Physical accessibility, however, remains a considerable barrier for many people with disabilities. Silvers (1998) described physical barriers as the principle means of disablement for people using wheelchairs. She wrote:

From the standpoint of persons mobilizing in wheelchairs, disablement is experienced not as the absence of walking but as the absence of access to bathrooms, theaters, transportation, the workplace, medical services, and educational programs—all those opportunities most other citizens expect to access (p. 74).

Silvers discussion sharply contrasts society's imagine of the "wheelchair bound" individual, or the person who is "confined to a wheelchair," with the social model perspective that it is the lack of access to public places, and not the wheelchair, that is confining.

Attitudinal Barriers and Low Expectations. When barriers and accessibility are discussed, we often assume that these are issues in the physical world. However, people with disabilities are increasingly commenting on the ways in which people's attitudes and low expectations are significant barriers to their interactions in the social realm. Kelly (1999) described first hand her experience as a woman who has used a wheelchair her whole life. Attitudinal barriers are a daily experience for her:

People can be so focused on my being in a wheelchair that they don't even hear me saying I don't need any assistance. This is the part that is so demoralizing, that continues to astound and sometimes enrage me. How do I explain this in the thirty seconds I might have before we both rush off in separate directions? How do I tell someone that what she thought was a helpful gesture was comparable to someone locking their car doors for no reason other than a young black man was walking by? That just because a prejudice led to a *kind* act doesn't mean it's not still prejudice? (Kelly, 2003, p. 71).

Kelly's experience of a "helpful gesture" being a sign of prejudice is especially thought-provoking. While clinical social workers are not necessarily physically holding doors open for people in wheelchairs, the profession has a legacy of being oppressive while attempting to be helpful (Mackelprang and Salsgiver, 1996). In what ways are we holding the door open for people who would prefer to open their own doors?

Limited Opportunities. Barnes, Mercer, and Shakespeare (1999) argued that people with disabilities, especially for people of color and women, continue to be excluded from employment. When people with disabilities are able to find work, it is often the least desirable kind due to their limited educational opportunities and inaccessible work places. Barnes, Mercer, and Shakespeare noted that there is some optimism about an increase in employment for people with disabilities because of more flexible working environments, but argue "in the absence of policies aimed at the creation of a barrier-free work environment the outlook for the majority of disabled people of working age remains bleak" (1999, p. 116).

Abuse is an extreme, but unfortunately a real form of being limited and controlled by able-bodied people. Victimization by caretakers is a major issue for certain people with disabilities. Platt (1999) wrote about the abuse people with disabilities are subjected to by paid and unpaid caretakers. Her description of being controlled is comparable to a

prisoner's narrative:

Often people who grow up disabled have no other reality than that of constant control and disempowerment. They learn at an early age to keep their choices and opinions to themselves, and somehow manage to create a space amid oppression and abuse. Even if the violence is recognized for what it is, what choice exists? How can you leave a situation when the person abusing you is the one who gets you dressed and washed for the day? Too many people with disabilities have spent years in back bedrooms, bound to beds for lack of wheelchair or trapped in their inaccessible home. Escape is not even remotely possible. For some of us, our only freedom may be in our silent thoughts that defy control (Platt, 1999, p. 182).

How Accessible is the Social Model of Disability?

Dowse (2001) critiqued the social model noting, "firstly there is as yet no Plain English version of the social model" (p. 137). While one of the goals of this theoretical exploration is to bring the concepts of the social model into the actual work of narrative therapists and their clients, the transition from theory to practice will certainly not come easily or smoothly.

While Dowse (2001) was concerned that people with cognitive impairments cannot access the concepts in the social model, I would also argue that this model, like all academic models, is not accessible to most people outside of academic settings. Are concepts from the theory relevant to a larger audience and can they be brought to this audience? This question will be considered further when the integration of the social model into narrative therapy practice is discussed.

Disability Versus Impairment

The separation of a socially constructed *disability* from a biological impairment has been essential to the creation of a social model of disability. Disability is articulated as a construct of society, while impairment is located within an individual's body. Corker

(2001) suggested that this separation is similar to a feminist division between sex and gender, but warns that this divide often creates an overly simplistic account of complex concepts that frequently overlap.

Dowse (2001) contended that by focusing on biological definitions of impairment, we leave out people with learning disabilities. Learning disabilities are generally “diagnosed” by the educational system, rather than through the medical system. Both Corker (2001) and Dowse’s arguments point to the diversity of people and their impairments and the inevitable problem of using one word, such as disability or impairment, to describe a great many conditions.

Social Constructionism

Social constructionism is a crucial concept for both disability scholars and narrative therapists. Rothman (2003) described the social construct model,

Social construct theory develops a position that demands a rethinking of the ways in which we consider any person’s place in society and any person’s rights as member of a society. It demands that we think of society not as an amorphous group of people, but as a group of people, some of whom have *built* the world that they all inhabit. This built world includes physical structures, and also institutions, laws, and programs (p. 11).

Disability studies writers have considered both ways in which disability and “normality” have been constructed within our society. It is also worth noting that disability is not a universal concept across place and time.

In *The Rejected Body*, Wendell (1996) has written extensively on the socially constructed origins of disability. She has highlighted the fact that people with disabilities are not given the resources they need to be fully included within society. This in itself is a means by which disability is socially constructed. Wendell has articulated two important

points. First, non-disabled people receive a lot of assistance in the form of education, training, social support, public communication and transportation facilities, public recreation, and in other ways. Second, people with disabilities need help because frequently their bodies have been damaged by social conditions (such as war or poverty), or because they cannot meet social expectations, or because physical structures and social organizations have been created without considering people with disabilities. Wendell deflects the issue of disability back on to society, rather than allowing it to rest solely within individuals.

Wendell (1996) noted the role of culture in the construction of disability. She wrote:

Culture makes major contributions to disability. These contributions include not only the omission of experience of disability from cultural representations of life in a society, but also the cultural stereotyping of people with disabilities, the selective stigmatization of physical and mental limitations and other differences (Selective because not all limitations and differences are stigmatized, and different limitations and differences are stigmatized in different societies), the numerous cultural meaning attached to various kinds of disability and illness, and the exclusion of people with disabilities from the cultural meaning of activities they cannot perform or are expected not to perform (Wendell, 1996, pp. 42-43).

Wendell (1996) used *pace of life* as an example of something that is socially constructed, which non-disabled people take for granted, but which can be marginalizing for some people with disabilities. In this example a person with a disability in a country with a slower pace of life might be less stigmatized by an impairment that kept him from moving quickly throughout the day than if he lived in a fast-paced society, like the United States.

The Reality of Impairment

Some disability scholars have argued that there must be a balance between considering the social construction of disability and the impact of an impairment on an individual (Brown, 2000; Donaldson, 2002; and Wendell, 1996). Wendell (1996) wrote:

I believe that in thinking about the social construction of disability we need to strike a balance between, on the one hand, thinking of a body's abilities and limitations as given by nature and/or accident, as immutable and uncontrollable, and, on the other hand, thinking of them as so constructed by society and culture as to be controllable by human thought, will, and action. We need to acknowledge that social justice and cultural change can eliminate a great deal of disability while recognizing that there may be much suffering and limitation that they cannot fix (1996, p. 45).

Brown (2002) suggested that aspects of the impairment need to be acknowledged by people with disabilities in order to be included within society. Giving the examples of pain and fatigue, Brown has asked: "How will mainstream society ever be able to incorporate us into itself if neither we nor it recognize pain and/or fatigue as part of who we are?" (Brown, 2002, p. 49). Donaldson (2002) also stressed that the material condition of the body cannot be ignored and that theories that ignore this existence of this sphere have limited political value.

There continues to be disagreement about whether social model theorists have included the actual experiences of people with their impairments within the model. Silvers (1998) contended that the social model of disability does not ignore the fact that disability "is to be at a heightened risk for suffering" (p. 90). However, she argued that its primary focus is on the lack of accessibility within the physical and social environments.

In "The Making of the Disabled Identity: A Linguistic Analysis of Marginalisation," Galvin (2003) articulated that the social model of disability should be

extended to include an analysis of a *disabled identity*, i.e. the negative status imposed by society on people who become impaired. This perspective responds to the argument that the social model ignores personal experiences, but continues to acknowledge the influence of society on people with disabilities.

These critiques and extensions of the social model of disability are important to consider and keep in mind as we explore how the model could be useful to narrative therapists. Certainly, there is the possibility of ignoring or disenfranchising individuals' experiences with their own bodies and minds. Within the context of clinical social work practice, however, this focus on the individual bodily or mental experience has been overly pervasive to the point of denying societal influences on people with disabilities. Social work practice has been too heavily influenced by the medical model, which is a model that locates the problem of disability almost exclusively within the individual. The challenge for social workers is whether they can, through narrative therapy practice and knowledge of the social model of disability, begin to understand the ways in which disability is socially constructed and integrate this into their clinical practice.

The Language Problem

“We encounter the problem of definition as soon as we take an interest in disability” (Wendell, 1996, p. 11). There are no perfect words to describe disabled people or their impairments, as Susan Wendell suggests. I have struggled to find satisfactory terminology since I first became interested in disability. I remain disappointed in the available choices. In the following section I hope to examine basic vocabulary related to disability. My goal, however, is not to promote any particular vocabulary as being

superior to another.

What Does Disability Mean?

Linton (1998) wrote that “the term *disability* is a linchpin in a complex web of social ideals, institutional structures, and government policies”(Linton, 1998, p. 10). The fact that disability means different things in different settings is important to remember. For example, someone diagnosed with bipolar disorder may not consider herself disabled, even though she receives disability benefits. On the other hand, another woman who is also diagnosed with bipolar disorder, who is employed full-time and does not receive any disability benefits, may consider herself a disabled activist. I am aware that as social workers, when we think of disability, we think first of government subsidies and benefits available to disabled people. Here, however, I focus primarily on disability within the social realm.

Barnes, Mercer, and Shakespeare (1999) made the important point that disability is not a universal term or concept across languages and cultures. Silvers (1998) argued that the concept of *the disabled* is an invention of the twentieth century, as previously people were described by specific impairments. While I will not elaborate on the historical development of disability within our society, I would encourage readers to remember that the concept of disability does have a historical context.

Impairment

The distinction between disability and impairment, or the more biologically-oriented term, is a fundamental tenet of the social model. I will use both terms throughout this work in order to acknowledge that people reside in both biological and social realities, even though I will continue to focus primarily on the social implications of

disability. An example of an impairment would be being HIV positive. According to a social model of disability, this impairment becomes disabling when an individual is denied access to healthcare, work, or education because of their HIV positive status.

What Words to Use?

Almost every author who writes on the subject of disability appears to struggle in some way with what language to use. Social model theorists (Barnes, Mercer, and Shakespeare, 1999) tend to favor *disabled people* in order to acknowledge that people are disabled by social interactions, rather than possessing a disability within themselves. According to Silvers, Wasserman, and Mahowald (1998), American disability activists have preferred the term *people with disabilities* in order to emphasize that “disablement does not reduce the essential inner person, however much it oppresses the contingent social person” (p. 10).

Barnes, Mercer, and Shakespeare (1999) noted that if impairments continue to be defined in negative terms, people with disabilities will continue to be shunned, excluded, pitied, patronized, and viewed as victims. As Swain, French, and Cameron (2003) explained, “placing the word ‘disabled’ before the word ‘people’, on the other hand, is a political statement arising from the understanding that disability is ‘done to people rather than being something that they ‘have’” (p. 14).

Barnes, Mercer, and Shakespeare (1999) pointed out that there is no universal consensus among people with impairments about preferred language. However, they suggested that critiquing language has been an important part of the overall critique of medical and social sciences treatment of people with disabilities.

Wendell (1996) argued that *people with disabilities* is preferred:

In addition, people with disabilities often express a strong desire not to be identified with their bodily weaknesses, inabilities, or illnesses. This is why the phrase “people with disabilities” has come to be preferred over “disabled people.” When the world sees a whole person as disabled, the person’s abilities are overlooked or discounted. It is easy to slip into believing other people’s perceptions of oneself, and this can take a great toll on the self-esteem of a person with a disability. Those people with disabilities who still have impressive and reliable physical abilities can counteract people’s misperceptions by asserting those abilities. For those of us whose remaining physical abilities are unimpressive or unreliable, not to identify ourselves with our bodies may be the best defense. It is a good psychological strategy to base our sense of ourselves, and therefore our self-esteem, on our intellectual and/or emotional experiences, activities, and connections to others (1996, p. 176).

While I have been heavily influenced by the social model theorists and understand their use of *disabled people*, I have determined primarily to use the person-first language, *people with disabilities*. I feel that this is more commonly used among North Americans. My hope, however, is that eventually people will become more familiar with the social model of disability and would, at that point, come to appreciate the political implications of using the term *disabled people*.

Ableism

The concept of ableism continues to fuel my desire to write about disability. When I use this word with social workers and people in general, they generally think I have made it up. In order to contest the notion that I have concocted the term, I began this study with the Oxford English Dictionary’s definition of the word: “Discrimination in favour of able-bodied persons; prejudice against or disregard of the needs of the disabled” (Simpson, J, 1997). Linton (1998) has written about the importance of this word:

It has been particularly important to bring to light language that reinforces the dominant culture’s view of disability. A useful step in that process has been the construction of the terms *ableist* and *ableism*, which can be used to organize ideas

about the centering and domination of the nondisabled experience and point of view (Linton, 1998, p. 9).

In many ways the concept of ableism is larger than any one model of disability. Butler and Parr (1997) suggested that ableism might be a superior concept because it does not deny the “mind and body states” in the same way the social model of disability frequently does. Understanding the presence of ableism in mainstream society and within the helping professions is fundamental to any work we do with people with disabilities. A more in depth look at ableism, especially within the field of social work, is presented in the fifth chapter.

CHAPTER III

NARRATIVE THERAPY

Of the various therapeutic models that I have been exposed to, narrative therapy seemed to have the most potential for working with clients with disabilities. The process of deconstructing dominant discourses makes narrative therapy a valuable model for working with populations who have been categorically marginalized by their society. In addition, the respect for people's lived experiences over professional assessment and diagnosis offers a powerful substitute to other models.

Although narrative therapy is a fairly new field within family therapy, theorists on several continents have produced an abundance of literature. It is not possible to capture all of the diverse voices within the field in this review. Therefore, this examination of narrative therapy will be limited to exploring only major concepts and then looking more specifically at work that is already being done with people with disabilities.

A Postmodern Perspective

The word *postmodernism* is a single word used to describe an expansive and complex concept. The term appears in literature across disciplines, but it is worth considering a working definition for this theoretical study. Monk, Winslade, Crocket, and Epston (1997) in *Narrative Therapy in Practice: The Archaeology of Hope* defined postmodernism as:

A philosophical movement across a variety of disciplines that has sought to dismantle many of the assumptions that underlie the established truths of the modern era. It is marked by acceptance of plurality and the challenging of norms. In particular, postmodernism tends to reject the view that science and technology

necessarily provide hope for human progress (1997, p. 304).

The aspect of postmodernism that rejects of universal truths, rules, and norms is particularly important when considering concepts from other therapeutic models that have been abandoned by narrative therapists.

Another idea that is important when reviewing narrative therapy foundations is *poststructuralism*. Hoffman (1992) argued that ‘poststructural’ and ‘postmodernism’ are often used interchangeably. Monk et al (1997) defined poststructuralism as,

A set of ideas that can be called postmodern but that, following Michael Foucault, critically examine structuralist concepts of truth, reality, self, and culture. This way of thinking rejects the idea that power is centralized in the major structures of society. It also rejects the idea of social structures as natural or given. Instead, power is understood as diffused throughout society as a result of the function of discourse (p. 304).

The structure that I have chosen to focus on for the purposes of this theoretical study is disability. In addition I am considering ways in which ableist discourses have an impact on people with disabilities.

Narrative Therapy as Part of Psychotherapy's Third Wave

O’Hanlon (1994) in “The Process of Narrative: The Third Wave,” described three waves of psychotherapy that are useful for differentiating narrative from other psychotherapeutic approaches. The First Wave, which began with Freud, is pathology-focused, and dominated by both psychodynamic theories and biological psychiatry. While O’Hanlon pointed out that First Wave therapists do not view people as morally deficient, as they had been previously portrayed, he argues that they give too much authority to diagnoses.

The Second Wave, as defined by O’Hanlon (1994), is made up of problem-focused therapies, including behavioral therapy, cognitive therapy, and family therapy. It does not assume that clients are sick, and the focus of the therapy is on the present situation. O’Hanlon believed that there were some power shifts with the emergence of this wave, as more women became therapists and psychiatrists were less glorified. However, adherents of this view still see therapists as having the solutions to fix clients’ problems. Problems are also solved on the level of the individual.

O’Hanlon (1994) described the Third Wave as arising in several different places at the same time in reaction to the inadequacy of the first two waves of psychotherapy. O’Hanlon viewed the Third Wave as acknowledging the power of history and culture in shaping our lives and the emancipating effects of recognizing these influences. O’Hanlon clearly situated narrative therapy within the Third Wave, referring to it as “a politics of liberation on a very individual level” (1994, p. 24).

While O’Hanlon’s (1994) discussion of the three waves of psychotherapy is a useful tool for considering loose thematic subgroups of psychotherapy, the waves should not be viewed along a linear, historical continuum. An individual therapist or an agency may borrow practices from all three waves. The First and Second Wave should not be viewed as “old” approaches with the Third Wave now dominating, but as coexisting with emerging Third Wave concepts.

The Narrative Metaphor

In *Narrative Means to Therapeutic Ends*, White and Epston (1990) defined the *narrative mode of thought* as “characterized by good stories that gain credence through their lifelikeness” (1990, p. 78). They also argued that rather than leading to certainty, as

the logico-scientific mode of thought attempts to do, the narrative mode leads to varying perspectives.

Zimmerman and Dickerson (1994) reviewed several advantages of the narrative metaphor in their article, "Using a Narrative Metaphor: Implications for Theory and Clinical Practice." The first advantage to narratives was that they evolve over time and are fluid. Second, the narrative metaphor uses experience as a primary variable, unlike the cybernetic metaphor, which uses information as the primary variable. The third advantage is that the therapist creates a context for change, but the client, with her experience being larger than her story filled with problems, is the one who is able to intervene with her own problem.

Social Constructionism

Social constructionism is a fundamental concept within both narrative therapy theory and the social model of disability. Freedman and Combs (1996) in *Narrative Therapy: The Social Construction of Preferred Realities* articulated that social constructionism, along with narrative, were the guiding metaphors of their work. They defined the main premise of social constructionism as:

The beliefs, values, institutions, customs, labels, laws, divisions of labor, and the like that make up our social realities are constructed by the members of a culture as they interact with one another from generation to generation and day to day (Freedman and Combs, 1996, p. 16).

Language

Language is a major area of discussion for narrative therapists. Social constructionists' emphasis on language and its influence on human behavior and beliefs (Monk & Gehart, 2003) have had a major impact on narrative therapy. Language's

emergence from cultural practices (Monk & Gehart, 2003) means that reexamining the way we use language is crucial to understanding the stories we tell about ourselves.

Anderson and Goolishian (1988) argued: “To ‘be in language’ is a dynamic, social operation. It is not a simplistic linguistic activity” (p. 377). An example of language as a social operation is the creation of a problem. According to Anderson and Goolishian, “problems, as alarmed objection, are a form of co-evolved meaning that exists in ongoing dialogical communication” (1988, p. 379).

Another example of how language and social constructionist thought affect clinical work is the shift in the meaning of diagnosis. Anderson and Goolishian (1988) suggested that both therapists and clients should create a diagnosis or “problem definition” together:

‘Diagnosis,’ in this view, is little more than a continuing conversation with all who are sharing a mutual concern and alarm. This concern does not mandate consensus; consensus regarding the nature of a problem is rarely achieved. Diagnosis takes place in a conversation that will produce constantly evolving and changing stories and meanings (p. 387).

Freedman and Combs (1996) discussed the social constructionist perspective, which is espoused by narrative therapists, asserting that our realities are constructed through social processes such as dialogue and language. In the following excerpt, Freedom and Combs described how we reify social meanings by using labels:

When we talk about ‘codependency’ or ‘schizophrenia’ or ‘narrative therapy,’ it is important to remember that we are actively perpetuating the social construction of these concepts as real elements in the fabric of our daily existence. We all too easily forget that other typifications might lead to the perception of other possibilities (1996, p. 24).

Richert (2003) suggested that narrative therapists focus on the processes that

create meaning, regardless of whether the dialogue is with a real person or imagined others. Freedman and Combs (1996) emphasized that the action of speaking is never neutral or passive and that the 'logic' of language often leads people to believe that what is described by language is real, when there are other possibilities for describing and legitimating the social world.

Multiple Narratives

The following section examines the possibility of various narratives to describe the lives of individuals. First, a *problem-saturated story* is "the story that a client presents to a therapist in which the problem is so dominant that there at first appears little sign of any alternative story" (Monk, et al., 1997, p. 305). The problem-saturated stories told about people with disabilities, by their families, communities, and themselves will be considered further in the next chapter.

The action of *reauthoring* will also be considered. Monk et al. describe the process as, "developing an alternative story in therapy" (1997, p. 305), stressing that in narrative therapy this is a collaborative project between counselor and client. This process will be especially important when working with people who have disabilities, as they frequently have not had the ability to author their own life stories or they have internalized negative societal attitudes about themselves.

Problem-Saturated Stories

Narrative therapists have much to say about the problems identified within clients' lives. As mentioned previously, a major tenet of narrative therapy is, "The person is not the problem. The problem is the problem." Anderson and Goolishian (1988) defined *problems* as, "linguistic events around which there is often conflicting

interpretation” (pp. 388-389). Reconsidering the location of a problem can be both innovative and controversial. Both narrative therapy theory and the social model of disability require that people reconsider the placement of the problem outside of individual people.

Monk and Gehart (2003) noted that social constructionist therapy, such as narrative therapy, places problems within sociocultural and relational contexts, rather than within individuals. They also examine how the action of externalizing problems can lead to more empowering life stories for clients.

Perhaps narrative therapy’s most distinctive feature, externalizing conversation, creates space between clients and problems to counteract oppressive, problem-saturated stories, thereby altering clients’ relations to problems. Externalizing requires therapists to identify oppressive problem discourses and their effects on clients, and allows clients to locate problem stories within a community’s dominant discourses rather than within themselves (Monk & Gehart, 2003, p. 25).

By externalizing problems, clients are able to move away from problem-saturated stories and then reauthor their life stories. A related concept is *deconstruction*, which Monk et al. (1997) define as “the process of unpacking taken-for-granted assumptions and ideas underlying social practices that masquerade as truth or reality” (p. 302). Deconstruction will be an especially useful tool when considering ableist narratives in later chapters.

The Reauthoring Process

Freedom and Combs (1996) noted that when people’s life narratives carry harmful meanings or offer only undesirable choices, these narratives can be changed by highlighting life events that were previously untold. When people are part of populations in which the dominant societal story about them is oppressive, they can choose instead to

find stories within subcultures that are resisting the dominant oppressive narrative. In chapter four, groups that resisted or reacted against the dominant stories are examined.

Epston, White, and Murray (1992) outline three purposes for re-authoring in the context of therapy. The first purpose is to enable people to separate their lives and relationships from impoverishing “knowledges/stories”. In doing this, they are able to question the importance and influence these stories have within their lives. A second goal is for people to challenge practices of self and relationship that are oppressive. This is especially crucial when we think about people who are in oppressive relationships or who are oppressed by the larger society. The third purpose is to encourage people to re-author their lives according to alternative “knowledges/stories” and practices that have preferred outcomes for them and their relationships. This process acknowledges that there are always multiple stories we could be telling about ourselves and that some will be more empowering than others.

Narrative Work with People with Disabilities

Many narrative therapists have already written on illness and disability (Freedman & Combs, 1996; Morgan, 1998; and White & Denborough, 1998). The Dulwich Centre Community Mental Health Project is an important example of how narrative therapy has questioned mainstream practices with people who have been diagnosed with mental illnesses and how they have brought credibility and voice back to people receiving mental health services at the Center.

It [The Dulwich Centre Community Mental Health Project] also questions the cultural practices in everyday interactions and ways of speaking that privilege certain ways of being which are then described as ‘normal’. These ‘normative’ ways of being are generally unobtainable and/or undesirable to community members. Questioning the origin and validity of these practices can be an

empowering and invigorating process (White & Denborough, 1998, p.13).

Hearing Voices

An important example of questioning mainstream practices has been the validation of the experience of “hearing voices” for clients who are traditionally labeled as psychotic (White & Denborough, 1998). Therapists and clients then work on looking at ways in which these voices can be problematic and disempowering for the client and think of ways to work with the voices to improve the clients’ daily experiences. The shift in language away from a diagnostic category, such as schizophrenia, toward a person’s own description of her experience opens up possibilities unimagined within more rigid approaches.

Acknowledging Disability Discrimination

Hastings (1997) argued that it was time for a disability critique of psychological theories. She articulated that most discrimination against people with disabilities is not official or blatant, but has a strong subtle presence: “There is hidden, unofficial discrimination embedded in our community, including in a human services, embedded in such a way that it is hard to define” (Hasting, 1997, p. 8). An example of discrimination within clinical programs is the assumption within most developmental theories that all humans start off the same way and go through mainstream developmental processes. As a person with an early childhood disability, Hastings did not recognize herself in such theories.

Critique

While most of this discussion on narrative therapy has focused on the potential inherent in narrative therapy, it is important to acknowledge that critiques of narrative therapy exist as well. For example, collaborative therapists, as part of the solution-focused movement, argue that the narrative approach is too directive and political, and that it may create another kind of oppression by forcing a client to create an alternative story, creating another kind of oppression (Monk & Gehart, 2003). Although this is certainly not an intended goal within narrative therapy, therapists must be careful to avoid pushing their own social or political agendas onto their clients.

This brief overview of narrative therapy is intended to create a reference point for future discussions of narrative practices within this study. An understanding of the role of mainstream and alternative stories; the process of externalizing problems and re-authoring narratives; and narrative therapy's postmodern and social constructionist foundation will be essential for integrating information within the remaining chapters.

In the next chapter, we will take a step back from person-to-person interaction within narrative therapy and look at two groups who are already telling alternative stories about themselves. Hopefully these group narratives will provide a broader range of possibilities for considering the lives of people with disabilities.

CHAPTER IV

EXAMPLES OF ALTERNATIVE STORIES

The purpose of this chapter is to present narratives by people whom society considers disabled. I chose two distinct groups of people in order to explore the ways in which different groups have resisted and rebelled against the dominant disabling narratives that society has constructed about them. The two groups presented in this chapter are: (1) the Deaf Community and (2) the Psychiatric Survivor/Consumer movement. I write about both of these communities as an outsider, but I believe social workers would benefit from exposure to stories such as these if we were going to confront ableism in our work.

While I write about these groups as if they each have an internally cohesive culture or ideology, it is important first to acknowledge the amount of diversity within each group. Dowse (2001) argued that “collective identities additionally are not fixed but rather express a relatively fragile social composition” (p. 132). My point in this chapter is not to suggest that these groups maintain a homogeneous group identity, but rather that they have been able to produce group narratives that resist the mainstream ableist narratives about themselves constructed by society.

Deaf Culture

I begin with the Deaf because they represent a large and vital group within the United States. There is extensive literature on Deafness, Deaf culture, and American Sign Language. My review is limited, but the focus is on narrative themes and relevant identity issues.

Big D or Little d?

Schapiro (1994) noted that a capital *D* is used by many when referring to cultural deafness and a lower case *d* is used to refer to the auditory condition. I primarily use a capital *D* because I am referring to people who are culturally Deaf, but not all people with the same auditory condition identify as being part of the cultural group. The perspective of someone who does not culturally identify as Deaf would be quite different than views of the community considered in this chapter.

In “Deafness as Culture,” Dolnick (1993) argued that although mainstream society still views deafness as an unfortunate plight, the Deaf community’s view of itself is strikingly different:

Lately, though, the deaf community has begun to speak for itself. To the surprise and bewilderment of outsiders, its message is utterly contrary to the wisdom of centuries: Deaf people, far from groaning under a heavy yoke, are not handicapped at all. Deafness is not a disability. Instead, many deaf people now proclaim, they are a subculture like any other. They are simply a linguistic minority (speaking American Sign Language) and are no more in need of a cure for their condition than are Haitians or Hispanics (p. 37).

The themes from the above passage that have emerged from Deaf perceptions of Deaf people include: a sense of community, a common culture, and a shared language. Feelings of loss or longing to be part of the hearing world are not included in the sense of collective identity. The notion of cure is rejected, as is even the concept of disability. Silvers, Wasserman, and Mahowald (1998) contended that people who are consider themselves culturally Deaf communicate so effectively through American Sign Language that they do not considered themselves impaired in any way.

The Deaf rejection of cure has become apparent with the invention of cochlear

implants. As discussed in Chapter Two, cure is highly valued within the medical model. The medical community has touted cochlear implants, endearing the implants to mainstream society. Dolnick (1993) pointed out that Deaf people have challenged the idea that medical treatment is a welcome sign of progress through their resistance to cochlear implants, especially in children. Although deaf children are usually born to hearing parents, who generally welcome the concept of a cure, the Deaf community has been active in advocating a different approach for the treatment of these children, arguing for American Sign Language education instead.

The debate around cochlear implants creates a useful context for considering how deafness is viewed. While hearing parents tend to view deafness in their children as a deficit, something to be overcome or fixed, Deaf people consider having a Deaf child to be a cause for celebration (Silvers, 1998). The Deaf community considers ways in which their physical and social environment have been inadequate, rather than viewing their bodies as inadequate.

Deaf President Now

The 1988 “Deaf President Now” movement at Gallaudet University, a major Deaf university, was a striking example of Deaf people rejecting the notion that to be hearing is better. Shapiro (1994) wrote, “the 1988 Gallaudet uprising was a primal roar of rebellion against decades of an expectation to adopt the dominant hearing culture and its demands for oralism, at the forfeiture of a rich deaf identity” (p. 99). According to Shapiro, much of the impetus for demanding a Deaf president was created by students and alumni who had grown up with Deaf parents. Their self-confidence contrasted sharply with the larger society’s view of them. According to Shapiro, the world of the Deaf, “to be unable to hear

is the norm, whereas society sees deafness as a pathology” (1994, p. 99).

Beyond a Social Model of Disability

In many ways, the pride and empowerment espoused by Deaf people appears to embrace a social model of disability, which I discussed in the second chapter. A strong rejection of the medical model’s concept of cure is present within the Deaf community. In addition, the social model concept of locating pathology in the environment instead of within the individual is represented.

The Deaf community is increasingly questioning the link between Deafness and disability. Jones (2002) argued that more and more people are considering Deafness using a cultural model. Jones articulated the significance of separating Deafness from “non-normality” and disability. In doing this, the Deaf are able to separate themselves from the stigma society has placed on people with disabilities. Brown (2002), an advocate of disability culture, suggested that Deaf people serve as an example to the larger disability culture movement, but he acknowledged that the Deaf community may, in fact, choose not to identify themselves with the people organized around the concept of disability.

D’Aoust’s (1999) perceptions of her own identity are of particular interest because she identifies as being a Deaf lesbian mother with a disability, but considers each of these identities as separate from one another. Her separation of her Deafness and her disabilities are noticeable:

When I participate in Deaf community activities, I am visibly different from others because I use a wheelchair. Deaf people are not disabled and I am a Deaf person with disabilities. As someone who was Deaf first, before becoming disabled, I can slightly understand the perspective of the ‘we are not disabled’ motto, because when I was not physically disabled, I did not feel an affinity or common bond with wheelchair users. I did identify with French or Spanish speakers or anyone speaking a language other than English and with Blind people

who read Braille or formats that are alternative to the printed word. The issues I identified with concerned information, communication and language. My experience as a Deaf person was an experience of culture, fun, partying, political networking and sometimes discrimination. It was not in my experience to feel 'disabled' by deafness even though I acquired my Deafness (as opposed to lost my hearing) as a teenager. Most Deaf people do not consider themselves disabled, not because they hate disability or think disabled people less worthy, but because they do not feel 'disabled' by being Deaf (D'aoust, 1999, p. 118).

While D'aoust's (1999) story is an important reminder of the complexity of identity and disability, it demonstrates the strength of the positive self-images of Deaf people compared to people within other disability communities. Her experience of "culture, fun, partying, political networking and sometimes discrimination" is a vital image of Deafness that is not widely acknowledged beyond the Deaf community itself. Her affirmative view of her own Deaf identity is the kind of empowering narrative that contrasts embedded ableist images of the Deaf.

Psychiatric Survivors and Consumers

In "Disability Studies and the Disability Perspective," Pfeiffer (2003) wrote that a key element of the disability perspective is that the person with a disability is a survivor. One group of people who have strongly identified with the concept of being a survivor is the members of the psychiatric survivor/consumer movement. While my discussion of the Deaf focused on a cultural reframing of disability, the following discussion looks at how a group examined the political nature of disability.

On Their Own: The Psychiatric Survivor/Consumer Movement

Breggin (1991) credited Judi Chamberlain with being one of the early leaders in the patient-run approach. Chamberlain had been through the psychiatric system as a patient and realized the importance of connecting with other people who had suffered

from similar psychiatric abuse. Again, we see a group that is rebelling against the medical model and finding strength within its own ranks rather than with outside professionals.

In *On Our Own: Patient-Controlled Alternatives to the Mental Health System*, Chamberlain (1978) described the incarceration of people labeled with mental illnesses.

The present mental health system focuses much attention on people who do not want help, people who have been defined as mentally ill and unable to judge their own best interests. This system necessitates involuntary commitment and forced treatment, and leads to the dehumanization of the patient (and to the more subtle, but no less real, dehumanization of mental health professionals). Although all is done in the name of care and concern, the underlying coercive nature of the system constantly makes itself felt” (p. xiv).

The passage above includes several key issues within the psychiatric survivor/ consumer movement. First, Chamberlain (1978) mentioned the labeling of people who are not interested in receiving services. As discussed in the second chapter, labeling has the power to stigmatize and separate people from mainstream society. Within the medical model, professionals have the power to label and patients become the passive recipients of such labels.

In addition, Chamberlain (1978) discussed the problems of involuntary treatment and dehumanization of both “the patient” and mental health professionals. Within a medical framework, mental illness is seen as a problem within an individual body, Chamberlain examined mental illness as a social creation and a systemic problem, examining the power differences between professionals and people labeled with mental illnesses.

Chamberlain (1978) argued that people experiencing mental distress might need

help at times. She asserted, however, that former mental patients frequently need help because of the disabling experience of psychiatric institutionalization and the process of being part of a stigmatized group. Chamberlain advocated for patient-controlled alternatives that would allow people diagnosed with mental illnesses to be active participants in their own recovery. Again, it is important to note that Chamberlain shifted the discussion about mental illness out of the individual body and into a social and political context.

Narratives Within the Movement

Hornstein (2002) in “Narratives of Madness, as Told From Within,” argued that patient narratives have a great deal to offer about the lives of people labeled with mental illnesses. Hornstein (2002) suggested that these narratives are a form of resistance:

Patient memoirs are a kind of protest literature, like slave narratives or witness testimonies. They retell the history of psychiatry as a story of patients struggling to escape doctors’ despair. Again and again, patients talk of having to wrest control of their treatment or cure themselves after some physician had given up on them (Paragraph 4).

In the passage above, Hornstein discussed the transition from passive to active as patients take control of their own treatment and begin the process of telling their own stories. In narrative therapy, this shift takes place as part of the deconstruction and reauthoring processes.

Themes Within Alternative Narratives

Alternative narratives told by groups are important examples of ways that the

dominant ableist narratives can be challenged. Many similar themes appear despite varying conditions. These themes include: (1) questioning the dominance of the medical model, (2) questioning the existence and importance of normalcy, and (3) advocating for more authority from within the group. In the next chapter, I discuss how the social model of disability can be integrated into narrative therapy work. These group narratives, as well as others not discussed here, are part of a history of people with disabilities that is frequently ignored. Clinicians would benefit from educating themselves about such group narratives in order to expand the possibilities they envision for clients with the therapy room.

CHAPTER V

CONFRONTING ABLEISM IN NARRATIVE WORK

In the previous chapters, I considered the social model of disability, narrative therapy, and examples of alternative stories about groups of people who are considered disabled. In this chapter I focus on bringing these concepts together in a way that both questions existing practices and stimulates the growth of further discussion. First, I discuss the precedent for integrating ideas from social activism into clinical work. Then I consider some dominant narratives about people with disabilities that reflect ableism in United States culture. Finally, I look at ways narrative therapists can work together with people with disabilities to reflect on the dominant narrative about disability in order to help clients reauthor their own stories.

Listening to the World Outside the Therapy Room

Throughout this theoretical study I have been interested in how mainstream narratives about disability enters into therapeutic work with clients with disabilities. I would argue that most clinical social workers are not fully aware of how ableism enters their work, but that by more education they could begin to understand its impact.

No practice is value free. In all clinical encounters, there are a multitude of possible interventions. The choice of intervention a given worker makes reflects many complex forces. These include the worker's values, theories, experiences, training, feelings, and ideas as well as an agency's goals, structures, and policies. In addition, the needs and interests of funding sources, including third party payers, licensing bodies, and policymakers have an impact. Finally, other social forces including racism, classism, heterosexism and sexism are in the mix that influences a worker's interventions (Sachs & Newdom, 1999, p. 3).

In the excerpt above, Sachs and Newdom (1999) argued that it is not possible to have

a therapeutic relationship where the values of the social worker, agency, and larger society are not present. I would add ableism to the list of social forces that influence a clinician's practice, despite the fact that ableism is not yet a widely discussed concept within social work practice.

While Sachs and Newdom (1999) do not come from a narrative therapy background, narrative therapists themselves have made similar arguments. For example, Russell and Carey (2003) argued that by its very nature therapy is political. They advocate for acknowledging the political nature of therapy and the power of the therapists in relation to the client.

If clinicians are to acknowledge the political nature of therapy, they must have a strong understanding of the politics that surround them, both on a micro and macro level. The consideration of feminist ideals is an example within narrative therapy of integrating political knowledge with therapeutic work. Russell and Carey (2003) connected the feminist mantra of 'the personal is the political' to practices within narrative therapy. One such practice is *externalizing problems* by locating them within historical and cultural contexts. Russell and Carey also see feminism and narrative therapy as a means of deconstructing dominant discourses about gender and having women question the unhelpful stories they tell about themselves within the framework of patriarchy. Therapists are urged to be more aware of gender and other power relations within the therapeutic relationship.

In "Temptation of Power and Certainty," Amundson, Stewart, and Valentine (1993) addressed "the disabling aspects of power and certainty" (p. 111) in the therapeutic context. While Amundson et al (1993) did not directly address power

dynamics between clients with disabilities and therapists without disabilities, their analysis of power in therapy is useful. Anderson, Stewart, and Valentine urged therapists to question not only their clients, but also themselves and their own disciplines. They pointed to the client's vulnerability with the therapeutic relationships, "like an underdeveloped nation, the client is ripe for colonization" (Amundson, Stewart, & Valentine, 1993, p.112). This analogy speaks to the difference of power between client and therapist, as the therapist is usually viewed as the expert. Amundson, Stewart, and Valentine suggested that therapists counteract this power dynamic by taking on an attitude of curiosity and a desire to empower. This advice is especially important for therapists working with clients with disabilities, as most therapists have little knowledge about specific impairments or the impact of ableism in client's lives. They will need to learn from their clients, who are the experts on their own lives.

As the French philosopher Michael Foucault has influenced both disability studies theorists and narrative therapists, his ideas about power are worth considering here. Flaskas and Humphreys (1993) argue that the most important ideas about power for therapists to contemplate are: (1) the productive potential of power, (2) power as relational, (3) the need to study power in the context of specific social relationships in which it occurs, and the (4) the possibility of resistance (p. 42). All of these ideas reflect Foucault's view of power as something that needs to be conceptualized in human relationships, rather than being thought of in the abstract. The relationship of power between a therapist and a client with a disability is crucial to consider. In addition, the power between people within clients' narratives should be carefully considered.

Ableist Narratives

The concept of “the problem” is an important tenet of narrative therapy. As discussed in the third chapter, narrative therapists locate the problem outside of people. In addition, the social model of disability does not identify biological impairments as problems, but articulates that problems are created by how society interacts with people with disabilities.

For the purposes of this study, I have identified a dominant ableist discourse as a problem for clients with disabilities. Anderson and Goolishian (1988) argued that the therapeutic system is a problem-organizing system and a problem-dis-solving system. In addition, they suggested that change occurs through the evolution of new meaning through dialogue. Their premises are important when considering ways in which narrative therapists and clients can look for alternative stories within the context of ableism.

What are the Dominant American Narratives About People with Disabilities?

In Chapter Two, the social model of disability was discussed in addition to the concept of ableism. Below, I discuss some of the major themes that are present in our societal narratives about people with disabilities. These major themes will, hopefully, facilitate a discussion about deconstructing and reauthoring stories using narrative therapy techniques.

Medical Dialogues. The dominance of the medical model has already been discussed. The importance of cure has permeated into our larger societal dialogue about bodies. La Fontaine (2003) discussed the goal of perfection within medical science in the context of the Human Genome Project:

In today’s so-called modern, progressive age, the study of genetics, in particular

the deployment of the Human Genome Project has created the notion that perfection is indeed possible using logical positivist methods. Medical science has, therefore, reinforced the paradigm that extreme forms of human diversity are undesirable by offering the global space an opportunity to rid itself of 'anarchic bodies'. People who are socially constructed as disabled are a primary target of this schema, particularly those who have conditions of a genetic origin (p.45).

La Fontaine's critique of the Human Genome Project offers an unusual perspective because this project has been so universally venerated. At the same time, we have to consider that this is a project that could potentially be beneficial to certain groups of people with disabilities. La Fontaine has asked us to consider the cultural consequences of seeking to create perfect humans.

A Hollywood Story. Cahill and Norden (2003) examined the way Hollywood depicted disabled women in film, emphasizing that both characters and plots involving disabled women have been narrowly defined. They concluded that Hollywood has typically used characters with disabilities "as a form of visual shorthand to illicit pity, fear, humour, or awe from the audience" (Cahill and Norden, 2003, p. 57). Cahill and Norden defined several characters for disabled women in film (2003, pp. 59-60). The "disabled ingénue-victim" is an attractive woman who is helpless because of her disability, but is usually cured by the end of the film. The "awe-inspiring overachiever" was in the top of her field prior to becoming disabled and learns how to "overcome" her disability to return to the top.

The current and historical representation of characters with disabilities in American film certainly has had an impact on the way people with disabilities are viewed and how they view themselves. The theme of cure is often present, as it is in medical discourses. Vulnerability and a sense of "otherness" are also important themes consistent

with society's larger story about people with disabilities. At the same time, Cahill and Norden (2003) observed that Hollywood fails to represent the daily struggles that people with disabilities face, including prejudice, access, and transportation issues. How do women with disabilities incorporate such media-created narratives into their own life stories and what are the implications of this?

The "Others". Silvers (1998) disagreed with the theory that nondisabled people fear people with disabilities because they see them as an omen of their own future.

Instead she argued:

Not displaced by fear but rather a commonplace cognitive mistake—namely, the failure to weigh realistically the likelihood that in the future one might suffer undeservingly—degrades the compassion with which the nondisabled might otherwise engage individuals with disabilities into distancing pity (Silvers, 1998, p. 49).

American culture values independence and productivity very highly. People with disabilities have frequently been denied the ability to possess these characteristics. Silvers (1998) considered the meaning of being viewed as weak in mainstream culture:

In contemporary Western culture, to be disabled is to be disadvantaged regardless of how much success one achieves individually. That is because costs are extracted if one is seen as a member of a poorly regarded group. Being identified with a 'weak' class invites oppression. This is the generic implication of 'disability' (p. 54).

Narrative Therapy's Toolbox for Confronting Ableism

The premise of this theoretical study is that using a social model perspective in narrative therapy has something to offer people with disabilities. At this point, I will discuss aspects of narrative therapy that could be beneficial for confronting ableism in therapy.

Beyond Diagnosis

A major feature of the medical model that people with disabilities have found oppressive is the dominance of diagnostic categorization. Narrative therapists have moved away from this means of defining people in order to gain thicker descriptions of the skills and knowledge of people requesting therapists (Russell & Carey, 2003).

Barrett (1991) discussed the “schizophrenic” label in “Psychiatric Practice and the Definition of Schizophrenia.” He noted that most individuals are originally seen as people, like everyone else, who are experiencing schizophrenia. Eventually, as they continue through psychiatric treatment they become “schizophrenics.” At this point their disability becomes their main identity. Barrett suggested that clinicians, through their interactions with clients and record keeping, often are contributing to the process of clients taking on a “schizophrenic identity.” While Barrett wrote specifically about people with schizophrenia, I would argue that clinicians are often in the position of contributing to clients’ views of themselves. For clients with disabilities, we must consider whether we are contributing to disabling identities or whether we are fostering empowering identities for people with disabilities, which move beyond their diagnoses.

In “Outside the Mainstream,” Thorne (1997) wrote about her own experiences with rheumatoid arthritis, which she has had since she was a child. She noted not only that others have labeled her in various ways throughout her life (from “cripple” to “differently-abled”), but also that at times she has become her disability. Thorne views her disability as one aspect of her life, but not as the only aspect of her life.

Deconstruction

People with disabilities not only face the ableism they experience when interacting with others, but they experience ableism that they have internalized within themselves (Brown, 2002). Narrative therapists can have a role in questioning both the assumptions that are made about people and the assumptions people have made about themselves because of their environment. Monk and Gehart (2003) argued that “in exposing the taken-for-granted ‘truths’ that dictate how to live and behave, narrative therapists aim to liberate people from society’s marginalizing practices that determine what is acceptable and unacceptable” (p. 20).

Thorne (1997) argued that as a person with a disability she had to live outside mainstream norms. As an example, she discussed her college experience, noting that the timeline for getting a psychology degree was completely outside the mainstream. Thorne acknowledged that the way success is constructed in society was not how she has had to define success for herself. As clinicians, recognizing that clients with disabilities are often carrying around mainstream ideals and deconstructing these ideals together is an important part of considering what it means to be disabled in our society.

Reauthoring

The reauthoring process is crucial to empowering people with disabilities through narrative therapy work. As we can see from some of the narratives coming out of the disability studies field, individuals are already actively engaged in telling their own stories, despite the oppressive nature of the stories others tell about them. Keith (1996) gave us the example of how wheelchairs are depicted:

It is distinctly a minority view to see the wheelchair as an object of liberation. For most people it symbolizes a vast range of negative attributes that include dependence, need, infirmity of mind and body, sickness, and a curious combination of the qualities, which are seen to pertain to both childhood and old age (1996, p. 76).

Brown's (2002) conception of how people with disabilities should fit into mainstream society is a foundation for reconsidering narratives about people with disabilities:

It is absolutely not our job to fit into mainstream society. Rather it is our destiny to demonstrate to mainstream society that it is to their benefit to figure out that we come attached to our wheelchairs, our ventilators, our canes, our hearing aids, etc. and to receive the benefit of our knowledge and experience mainstream society needs to figure not how we fit in, but how we can be a benefit exactly the way we are (Brown, 2002, p.50).

Brown's larger argument is that it is important to celebrate disability culture. The notion that disability could be a cultural experience or something worth celebrating is a story infrequently told outside of certain circles. Being open to alternative narratives such as this will be crucial to narrative therapists and clients as they work on the reauthoring process in their own work.

In "Narrative Perspectives in Psychosocial Interventions Following Adverse Life Events," Borden (1992) argued that a crucial component of adapting to an adverse life experience is the ability to incorporate the event into the ongoing life story. He uses several case examples, including the stories of people with chronic illnesses and disabilities. Borden wrote:

In adopting a narrative perspective, the clinician seeks to help clients understand reactions to adverse experience; explore the significance and meaning of events in view of prior perceptions of self, others, life experience, and anticipated future; restructure elements of the personal narrative to accommodate the implications of

the event; and identify sources of strength and continuity from accounts of earlier experience that may help the individual cope with the event (1992, p. 139).

While this passage has particular reference to people who became disabled after birth, and are consequently going through major perceptual shifts, it speaks to the larger concept of accommodating aspects of our lives that make us different from others. This is relevant to people with disabilities, as well as many other marginalized groups.

Narrative therapists have already begun the work of deconstructing mainstream narratives about disability. Incorporating concepts from the social model of disability has the potential to strengthen an existing practice by grounding it in an understanding of the construction of disability and the discourse of ableism.

CHAPTER VI

CONCLUSION

Both narrative therapy and a social model of disability have the potential to create more empowering possibilities in the work that clinical social workers do with people with disabilities. Joining these two theories is not without its challenges, however. These challenges will be considered here. In addition, questions for future research will also be contemplated.

Challenges

The purpose of this theoretical study has been to explore the benefits of using a social model perspective within narrative therapy practice. There will be multiple challenges for clinical social workers utilizing these concepts in their practice. Two major problems I have chosen to address here are: (1) the past history of social workers and people with disabilities and (2) the process of moving from a theoretical framework into practice.

Troubled History of Social Workers and People with Disabilities

Clinical social workers frequently work with people with disabilities, but they may not stop to consider the history of people with disabilities and social work. Clinicians need to be cognizant of this history, which disabled activists and theorists perceive as problematic. While I will not offer a full description of the past relationship between the field of social work and people with disabilities, I will consider the theme of power within that relationship.

Mackelprang and Salsgiver (1996) examined the history of people with

disabilities and social work and argued that social work, although it has much to offer people with disabilities, has been inconsistent in its service to them. For example, there continue to be few students and educators with disabilities, as well as a lack of writing on disability within the field of social work. Mackelprang and Salsgiver (1996) also noted that the tendency of social workers to help people who have not asked for help goes directly against the Independent Living Movement's ideology that individuals with disabilities should have control of services in their lives.

Barnes, Mercer, and Shakespeare (1999) also explore the reality that people with disabilities automatically become the passive objects of professionals:

To acquire an impairment is to become the object of professional attention. This 'expert' defines an individual's needs and how these should be met. The aim is to overcome, or at least minimize the negative consequences of the individual's 'disability'. The rehabilitative focus has underpinned a growing range of policy initiatives designed by various professional 'experts' to address the 'special needs' and 'personal difficulties' of disabled individuals (p. 21).

While this quotation does not directly name social workers, it is not difficult to see that social workers have often participated in the behaviors listed, such as defining the needs of people with disabilities rather than seeking to have people articulate their own needs.

Swain, French, and Cameron (2003) aptly described the authority (and the biases) that professionals, including social workers, receive from society by virtue of their status:

Professionals including doctors, social workers, psychologists and teachers are endorsed with institutional authority to make judgments and impose labels on people. By virtue of the recognized knowledge and qualifications they have gained through education, they are judged to have demonstrated their fitness to make valid pronouncements on the 'cases' with whom they deal. The education that they have received, however, has not taken place in a social vacuum but reflects existing relationships of power within society. Professionals are granted social power only as long as they conform with the codes of practice and values of their professions. The judgments that they make and the labels they impose reflect

particular cultural norms (p. 12).

It is imperative not only to note the fact of the authority given to professionals by society, but also the terms of that authority. Swain, French, and Cameron (2003) wrote from a Marxist perspective, which views professionals as ‘agents of social control.’ As a result, they argue, professionals individualize problems rather than looking at them on a systemic level.

Theory Into Action

Journal articles and books have shaped this theoretical project. I have sat alone in libraries or at my computer contemplating how narrative therapy and the social model of disability could be used together. Occasionally, I discussed these ideas with others. This project has certainly had an impact on my clinical work. These concepts, however, continue to exist primarily in their theoretical framework.

According to Anderson and Goolishian (1988), “social science theories are ideologies invented at a moment in time for practical reasons” (p. 373). There have been practical reasons for me to hold these two theories next to one another. I hoped to stress the significance of the social model of disability in the field of social work, start a discussion about empowering people with disabilities within clinical work, and produce questions about future research.

Ideas for the Future

Narrative therapists have consistently examined the role of societal oppression in their work. Hopefully, knowledge about ableism and the social model of disability will continue to grow within the field. A more in depth discussion of how other oppressions,

such as racism, overlap with ableism will be crucial. In addition, further study will be needed to determine how clinical social workers who use theoretical lenses, other than narrative therapy, can begin to confront ableism in their work with clients with disabilities.

Clinical social workers as a group continue to have limited information about newer theoretical frameworks about disability. It will be important for social workers to access literature from disability studies and to incorporate more about disability into their own literature. This will be a matter for social work programs to incorporate into their training programs.

Integrating an understanding of the social model of disability into narrative therapy practice can enable therapists and clients to deconstruct ableist narratives and elicit alternative stories that have empowering implications for clients with disabilities. Before clinical social workers will be able to help clients with disabilities invite alternative stories into the therapy, they will have to consider their own existing discourses about disability.

References

- Amundson, J., Stewart, K., & Valentine, L. (1993). Temptations of power and certainty. *Journal of Marital and Family Therapy, 19*(2), 111-123.
- Anderson, H. & Goolishian, H.A. (1988). Human systems as linguistic systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family Process, 27*(4), 371-392.
- Barnes, C., Mercer, G., & Shakespeare, T. (1999). *Exploring disability: A sociological introduction*. Malden, MA: Blackwell Publishers, Inc.
- Barrett, R. (1991). Psychiatric practice and the definition of schizophrenia. *Dulwich Centre Newsletter, 4*, 5-11.
- Borden, W. (1992). Narrative perspectives in psychosocial intervention following adverse life events. *Social Work, 37*(2), 135-141.
- Breggin, P.R. (1991). *Toxic psychiatry*. New York: St. Martin's Press.
- Brown, S. E. (2002). What is disability culture? *Disability Studies Quarterly, 22*(2), 34-50.
- Butler, R. & Parr, H. (1999). New geographies of illness, impairment and disability. In R. Butler & H. Parr (Eds.), *Mind and body spaces: Geographies of illness, impairment and disability* (pp.1-24). London: Routledge.
- Cahill, M.A. & Norden, M.F. (2003) Hollywood's portrayals of disabled women. In A. Hans and A. Patri's (Eds.) *Women, disability, and identity* (pp.56-75). New Dehli: Sage Publications.
- Chamberlin, J. (1978). *On our own: Patient-controlled alternatives to the mental health system*. New York: Hawthorn Books, Inc.
- Corker, (2001). Sensing disability. (2001). *Hypatia 16*(4), 34-52.
- D'aoust, V. (1999). Complications: The Deaf community, disability, and being a lesbian mom-A conversation with myself, in V. A. Brownworth and S. Raffo (Eds.) *Restricted access: Lesbians on disability* (pp.115-123). Seattle: Seal Press.
- Davis, L. J. (Ed.). (1997). *The disability studies reader*. New York: Routledge.
- Dolnick, E. (1993). Deafness as culture. *The Atlantic Monthly, 273*(3), 37-49.

- Donaldson, E.J. (2002). The corpus of the madwoman: Toward a feminist disability studies theory of embodiment and mental illness. *NWSA Journal*, 14(3), 99-119.
- Dorn, M. L. (1999) The moral topography of intemperance, in R. Butler and H. Parr (Eds.) *Mind and body spaces: Geographies of illness, impairment and disability* (pp.46-69). London: Routledge.
- Dowse, L. (2001). Contesting practices, challenging codes: Self advocacy, disability politics and the social model. *Disability & Society*, 16(1), 123-141.
- Epston, D., White, M. & Murray, K. (1992). A proposal for a re-authoring therapy: Rose's revisioning of her life and a commentary. In S. McNamee & K. Gergen (Eds.), *Therapy as social construction* (96-115). London: Sage Publications.
- Flaskas, C. & Humphreys, C. (1993). Theorizing about power: Intersecting the ideas of Foucault with the "problem" of power in family therapy. *Family Process*, 32, 35-47.
- Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. New York: W.W. Norton & Company.
- Galvin, R. (2003). The making of the disabled identity: A linguistic analysis of marginalisation. *Disability Studies Quarterly*, 23(2), 149-179. Retrieved August 13, 2001 from www.cds.hawaii.edu/DSQ/articles.html.
- Hastings, E. (1997). Hidden disability discrimination. *Dulwich Centre Newsletter*, 4, 8-11.
- Hoffman, Lynn (1992). Constructing the theoretical context: A reflexive stance for family therapy. In S. McNamee & Gergen (Eds.), *Therapy as social construction* (7-24). London: Sage Publications.
- Hornstein, G.A. (2002). Narratives of madness, as told from within. *Chronicle of Higher Education*, January 25, 2002, 48(20), B7-B11.
- Jones, M.A. (2002). Deafness as culture: A psychosocial perspective. *Disability Studies Quarterly*, 22(2). Retrieved August 13, 2003 from www.cds.hawaii.edu/DSQ/articles.html.
- Kane, R.A. (1982). Lessons for social work from the medical model: A viewpoint for practice. *Social Work*, July 1982, 315-321.
- Keith, L. (1996). Encounters with strangers: The public's responses to disabled women and how this affects our sense of self. In J. Morris's (Ed.) *Encounters with*

- strangers: Feminism and disability* (pp.69-88). London: Women's Press Ltd.
- Kelly, M. (1999). A dialogue on disability: To the person who 'helps' me. In V. A. Brownworth and S. Raffo (Eds.) *Restricted access: Lesbians on disability* (pp.68-73). Seattle: Seal Press.
- La Fontaine, M. (2003). Perfect? An analysis of the global human genetics fix. In A. Hans and A. Patri's (Eds.) *Women, disability, and identity*. (pp. 43-55). New Dehli: Sage Publications.
- Linton, S. (1998). *Claiming disability: Knowledge and identity*. New York: NYU Press.
- Mackelprang, R.W., & Salsgiver, R.O. (1999). *Disability: A diversity model approach in human service practice*. Pacific Grove: Brooks/Cole Publishing Company.
- Mackelprang, R.W., & Salsgiver, R.O. (1996). People with disabilities and social work: Historical and contemporary issues. *Social Work, 41*(1), 7-14.
- Monk, G., & Gehart, D.R. (2003). Sociopolitical activist or conversational partner? Distinguishing the position of the therapist in narrative and collaborative therapies. *Family Process, 42*(1), 19-30.
- Monk, G., Winslade, J., Crocket, K., & Epston, D. (Eds.). (1997). *Narrative therapy in practice: The archeology of hope*. San Francisco: Jossey-Bass.
- Morgan, A. (1998). Conversations of ability. In C. White and D. Denborough's *Introducing narrative therapy: A collective of practice-based writings*. (pp. 33-46). Adelaide, South Australia: Dulwich Centre Publications.
- Morgan, A. (2000). *What is narrative therapy? An easy-to-read introduction*. Adelaide, South Australia: Dulwich Centre Publications.
- Morris, J. (ed.). (1996). *Encounters with strangers*. London: The Women's Press Ltd.
- National Association of Social Workers (1999). *NASW Code of ethics*. Washington D.C.: author.
- O'Hanlon, B. (1994). The process of narrative: The third wave. *Family Therapy Networker, 18*(6), 18-29.
- Perry, L. (1998). Sarah-Jane's story. In C. White and D. Denborough's *Introducing narrative therapy: A collection of practice-based writings*. (pp. 77-90). Adelaide, South Australia: Dulwich Centre Publications.
- Pfeiffer, D. (2003). Disability studies and disability perspective. *Disability Studies*

Quarterly, 23(1), 142-148. Retrieved August 13, 2001 from
www.cds.hawaii.edu/DSQ/_articles_html.

Platt, M.F. (1999). Passing through shame. In V. A. Brownworth and S. Raffo (Eds.)
Restricted access: Lesbians on disability (pp.180-191). Seattle: Seal Press.

Richert, A. J. (2003). Living stories, telling stories, changing stories: Experiential use of
the relationship in narrative therapy. *Journal of Psychotherapy Integration*, 13(2),
188-210.

Rothman, J. C. (2003). *Social work practice across disability*. Boston: Ally and Bacon.

Russell, S., & Carey, M. (2003). Feminism, therapy and narrative ideas: Exploring some
not so commonly asked questions. *International Journal of Narrative Therapy
and Community Work*, 2. Retrieved August 29, 1001 from
www.dulwichcentre.com.au/feminism.htm.

Sachs, J., & Newdom, F. (1999). *Clinical work and social action*. Binghamton, NY: The
Hawthorn Press.

Schapiro, J. P. (1994). *No pity*. New York: Three Rivers Press.

Silvers, A. (1998). Formal justice. In A. Silvers, D. Wasserman, & M.B. Mahowald's
Disability, difference, discrimination (pp.147-208). Lanham, MD: Rowman &
Littefield Publishers, Inc.

Silvers, A., Wasserman, D., & Mahowald, M.B. (1998). *Disability, difference,
discrimination*. Lanham, MD: Rowman & Littefield Publishers, Inc.

Simpson, J. et al (Eds.). (1997). *The Oxford English dictionary* [electronic version](2nd
ed. Additions). Oxford: Oxford University Press.

Swain, J., French, S., & Cameron, C. (2003). *Controversial issues in a disabling society*.
Buckingham: Open University Press.

Thorne, K. (1997) Outside the mainstream. *Dulwich Centre Newsletter*, 4, 27-30.

U.S. Department of Commerce (1997). *Disabilities affect one-fifth of all Americans:
Proportion could increase in coming decades*. (Census Brief No. 97-5).
Washington D.C.: author.

Wendell, S. (1996) *The rejected body: Feminist philosophical reflections on disability*.
New York: Routledge.

- White, C., & Denborough, D. (1998). *Introducing narrative therapy: A collection of practice-based writings*. Adelaide, South Australia: Dulwich Centre Publications.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.
- Winter, J.A. (2003). The development of the disability rights movement as a social problem solver. *Disability Studies Quarterly*, 23(1), 33-61. Retrieved August 13, 2003 from www.cds.hawaii.edu/DSQ/articles.html.
- Zimmerman, J.L., & Dickerson, V.C. (1994). Using a narrative metaphor: Implications for theory and clinical practice. *Family Process*, 33, 233-246.